NEW / WELL PEDIATRIC PATIENT – BIRTH to 1 Year

MAGNIFICAT FAMILY MEDICINE

Name:_____Date of Birth: _____

Sex: Male☐ Female☐ Today's Date:_____

Accompanying Adult's Name/Relation: _____

Please tell us the **REASON FOR TODAY'S VISIT**:

_____

_____

Please list your child's **CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS:**

Name	Dosage (i.e., MG)	How Taken (i.e., 1 tablet daily)

Please list any **ALLERGIES** to medications/foods:

Allergy	Type of Reaction (i.e., rash, nausea)

IMMUNIZATION PREFERENCE (circle one): **Traditional** ☐ **Delayed** ☐ **None** ☐

INTERVAL HISTORY:

Nutritional Detail – Liquids:

Is child breast or bottle fed? ☐ Breast ☐ Bottle
If breast, how often? _____ oz/feeding
If bottle, how often? _____ oz/feeding
Type of formula:_____

Does your child drink: ☐ Milk _____ oz/serving
☐ Juice _____ oz/serving
☐ Water_____oz/serving

Solids:
Age when solids introduced: _____
Does your child eat: ☐ Baby Food ☐ Table Food

Elimination Habits – Bladder:

Any concerns about child's bladder or kidney health? Yes☐ No☐
Number of wet diapers per day:_____ times/day
Urine color:_____

Elimination Habits – Bowel:

Any concerns about child's bowel habits? Yes☐ No☐
Number of bowel movements (BM's):_____ times/day
Stool color: _____
Stool consistency: _____

BIRTH HISTORY:

Mother's age at child's birth:_____
Number of pregnancies:_____
Was prenatal care given? Yes☐ No☐
Any problems after delivery or newborn nursery care?
_____
Birth preventions: Hep B: ☐ Eye ointment: ☐ Vit K:☐

Type of Delivery: ☐ Vaginal ☐ C-Section
Term: ☐ Full Term ☐ Premature
Birth Weight: _____lbs. _____ oz
Birth Length: _____inches
Discharge Weight: lbs oz

For Nurse Use Only: Ht._____ Wt._____Temp._____ Pulse_____Resp._____ H.C. _____

DEVELOPMENTAL HISTORY:

Birth to 6 Weeks	Yes	No	2 Months	Yes	No	4 Months	Yes	No
Focuses on care-taker's face	☐	☐	Coos	☐	☐	Bears Weight	☐	☐
Lifts head	☐	☐	Fixed on objects and follows movement	☐	☐	Coos, squeals, laughs	☐	☐
Responds to sound	☐	☐	Follows past midline	☐	☐	Grasps	☐	☐
Turns head side-to-side	☐	☐	Grasps	☐	☐	Holds head/chest up with support	☐	☐
			Lifts head to 45 degrees	☐	☐	Holds small toy	☐	☐
			Smiles responsively	☐	☐	Reaches	☐	☐
			Vocalizes	☐	☐	Rolls	☐	☐
			Turns head to sound	☐	☐	Turns to sound	☐	☐

9 Months	Yes	No	12 Months	Yes	No
Babbles consonant sounds	☐	☐	Cruises	☐	☐
Claps, waves, peek-a-boo	☐	☐	Fills and empties containers	☐	☐
Creeps, crawls	☐	☐	Finds hidden objects	☐	☐
Gets to sit	☐	☐	Gets to sit	☐	☐
Mama/Dada	☐	☐	Holds cup and drinks	☐	☐
Pat-a-cake	☐	☐	Imitates words	☐	☐
Pincer grasp	☐	☐	Pincer grasp	☐	☐
Pulls to stand	☐	☐	Stands alone	☐	☐
Shake, bang, throw	☐	☐	Turns pages	☐	☐
Sits alone	☐	☐	Verbal skills: 1-2 words	☐	☐
Stands with support	☐	☐	Walks alone	☐	☐

Please provide age-appropriate **SOCIAL HISTORY:**

Primary Residence:
Who lives with your child? _____
_____

Tobacco Exposure:
Are there smokers at home? Yes ☐ No ☐
If yes, do they smoke outside only? Yes ☐ No ☐

Home Environment:
What is the age of the home?: _____
Is there lead in the home? Yes ☐ No ☐
_____
Spiritual beliefs/Religion: _____

Child Care:

Who provides care for your child?	#days/wk:
☐ Mother	_____ days/wk.
☐ Father	_____ days/wk.
☐ Grandparent	_____ days/wk.
☐ Other_____	_____ days/wk.
☐ Day Care	_____ days/wk.

Sleep:
Does child get 8.5 hrs. of sleep? Yes ☐ No ☐
Does child have sleeping problems? Yes ☐ No ☐
Does child take naps? Yes ☐ No ☐
Does child sleep with parents? Yes ☐ No ☐
Does child sleep through the night? Yes ☐ No ☐
What position does child sleep in?_____
_____

Safety:
Do you use a car seat? Yes ☐ No ☐
If yes, is car seat facing: Front ☐ Rear ☐
Is there a carbon monoxide detector? Yes ☐ No ☐
Are smoke detectors in the home? Yes ☐ No ☐
Are there firearms in the home? Yes ☐ No ☐
Are there pets in the home? Yes ☐ No ☐
If yes, what kind? _____

Please provide your child's **PAST MEDICAL HISTORY** & **SURGICAL HISTORY** date/year if known (for males, was a circumcision performed?):

_____

_____

Please provide your child's **FAMILY HISTORY:**

FATHER: ☐ Alive ☐ Deceased Age _____ Reason Deceased? _____
Health Problems_____

MOTHER: ☐ Alive ☐ Deceased Age _____ Reason Deceased? _____
Health Problems_____

BROTHERS AND SISTERS: (Each one: Are they living? Reason Deceased? Ages? Other health problems?)

_____
_____
_____

Does anyone in the family have these health conditions? (Please check even if listed above

_____Heart Problems
(Heart Attacks, Heart Failure)
_____Breast Cancer
_____Colon Cancer
_____Prostate Cancer
_____ Skin Cancer
_____ Diabetes
_____Strokes
_____Mood Disorders
(Anxiety, Depression, Bipolar, etc.)

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PHYSICIAN REVIEWED: _____ **DATE:** _____